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Prevention of Depression and Suicidal Behavior in Children and Adolescents and Its Polymorphic Characteristics. Review of Selected Studies and Programs

Polimorficzne wymiary profilaktyki depresji i zachowań suicydalnych dzieci i młodzieży – przegląd wybranych badań i programów

Keywords:
depression, suicidal behavior, suicide, children, adolescents, prevention

Summary: Depression, which is the main cause of suicidal behaviors, is becoming a serious social problem today, linked to approximately 90% of suicide cases. Current statistics and research indicate that the problem is escalating, affecting children, adolescents and adults. The complexity and multidimensionality of the determinants of depression and suicidal behavior require not only careful analysis, but, above all, the creation and implementation of effective prevention measures. The focus of the article, therefore, is on how to prevent depression and suicidal behavior in children and adolescents. On the basis of a careful review of current statistics and research on the subject, the paper offers original ideas on how to improve the existing preventive measures and lists some of the prevention programs which have been implemented in Poland and abroad. The effectiveness of these programs, as the author makes clear, depends on a variety of factors.

Słowa kluczowe: depresja, zachowania suicydalne, samobójstwa, dzieci, młodzież, profilaktyka

Streszczenie: Depresja, będąca głównym podłożem zachowań suicydalnych, współcześnie staje się problemem społecznym (około 90% przypadków samobójstw jest powiązanych z depresją). Aktualne statystyki i badania wskazują, że problem ten eskaluje, dotyczy zarówno dzieci i młodzieży, jak i osób dorosłych. Złożoność i wielowymiarowość czynników warunkujących depresję i zachowania suicydalne wymaga dokładnego przeanalizowania, a przede wszystkim skutecznej profilaktyki i jej realizowania. Kluczowe zagadnienie tekstu stanowi działanie profilaktyczne w zakresie depresji i zachowań suicydalnych dzieci i młodzieży. Opierając się na przeglądzie aktualnych (a zarazem ogólnych) statystyk i badań dotyczących tego problemu, przedstawiono autorskie propozycje zmian i udoskonaleń prowadzonej profilaktyki, a także propozycje wybranych programów profilaktyki depresji i zachowań suicydalnych dzieci i młodzieży realizowanych w Polsce oraz za granicą. Wskazano, że skuteczność tych programów zależy od wielu czynników.

Introduction

Depressive disorders, which are most often the main reason behind the manifestations of suicidal behavior,[1] are the greatest problem among children and adolescents today. Numerous studies and statistics show that it is growing year by year. The World Health Organization indicates that depressive disorders are developing so rapidly that in the near future, depression will be perceived as a form of "disability." Countries where suicidal behavior is developing the fastest are Lithuania (34.1%), Russia (30.1%), Belarus (28.4%), Hungary (24.6%), Slovenia (21.9 %) and Ukraine (21.2%) (WHO, 2014). The report entitled "Children Matter 2017 – Threats to the Safety and Development of Children in Poland," conversely, indicates that the country with the highest suicide rate is Germany. In 2014, there were 224 fatal suicide attempts of people under 19 in the country (statistics do not include survivors). In Poland, 209 such cases were recorded in the same year. France (171), Great Britain (134), Italy (87) and Spain (69) were also listed among the countries with the highest suicide rate (https://www.focus.pl/artykul/

[1] About 90% of suicide cases are associated with depression (Szymańska, 2012, p. 12).

samobojstwa-nieletnich-polska-na-drugim-miejscu-in Europe [accessed: 18.08.2019]). Research conducted by Irena Pospiszyl shows that in the last 10 years the number of people attempting suicide in Poland has doubled. For the 15–19 age group, it was 153 cases in 2010; 343 in 2012; and 526 in 2014 (after: Wasilewska-Ostrowska, 2015, p. 154). Moreover, according to data provided by the National Police Headquarters, in 2018, 746 adolescents aged 13–18 years and 1,143 young people aged 19–24 tried to commit suicide in Poland[2] (The National Police Headquarters, 2017).

The selected statistical data cited above prove that depression and suicidal behavior are increasing among children and adolescents. These are extremely complex problems with many causes, among which are genetic factors, family and personal environment factors, as well as factors related to individual life experiences. Researchers also indicate that depressive disorders occurring in a parent (or both parents) increase the risk of depression in children by three times. Some studies suggest that in most cases of depression at least 50% of the cause is genetic. However, others propose that it is environmental factors that play the biggest role here (Kalinowska et al., 2013, p. 33). Researchers who study gene-environment interactions explain the important role of genetics in one's predisposition to depression and anxiety, which is manifested by increased sensitivity to stressors. At the same time, however, they prove that factors related to the family environment (such as conflicts in the family, low socioeconomic status, death of one of the parents [especially the one with whom the individual was strongly associated], violence, sexual abuse, abuse of psychoactive substances, disturbed emotional bonds in the family, negative parental attitudes, lack of support and help, reorganization of family life and unavailability of parents, e.g., due to illness) contribute to the occurrence of depressive disorders and possibly suicidal behavior in the future (Veronica, Pisinger, Hawton & Tolstrup, 2018, pp. 201–208; Christoffersen, Poulsen & Nielsen, 2003, p. 350; Zaborskis, Sirvyte & Zemaitiene, 2016, pp. 1–15).

In addition to the determinants indicated above, researchers focus on those related to the social environment in which the individual functions on a daily basis, including improper relations with peers, romantic relationships (especially unsuccessful), as well as various stress-inducing situations. In the case of

[2] In 2017, the number for the 13–18 age group was 702, and was the same for the 19–24 age group.

children and adolescents, one can also talk about school-related factors, e.g., educational failures, repeating a school year, inappropriate relationships with teachers and classmates, few school achievements, no successful educational experiences, lack of help and support from the teacher, etc.[3]

The analysis of depression and suicidal behavior determinants in children and adolescents is a highly diversified and a profoundly complex process that involves a number of diagnostic procedures (often including a specialist diagnosis of not only the individual concerned, but also of the most important educational environments for them, i.e., family and school), as well as the knowledge of numerous integrated preventive and therapeutic activities. As indicated before, the focus of this article is on the prevention of depressive disorders and suicidal behavior. Its purpose is to present selected preventive measures and to offer original tips and suggestions for changes and improvements. This is complemented by a list of prevention programs already implemented by schools and institutions in Poland and abroad.

Depression and suicidal behavior prevention: towards transformation. Suggestions for changes and improvements.

According to Bronisław Urban (1995, p. 113), "prevention" can be defined as a set of activities undertaken by individuals, teams of specialists and non-professionals, and formal organizations and institutions. In holistic terms, it is associated with the developmental period of the life of children and adolescents, its duration and rhythm, the use of natural interpersonal relationships and the channels of socialization created in the process of human evolution. Similarly, the World Health Organization (WHO) indicates that "suicide prevention strategy should be multicenter and carried out at the level of the family, school, police, healthcare, government and local administration" (WHO, 2012). Suicide prevention in children and adolescents should, therefore, include:

- society-wide educational activities promoting the shaping of proper attitudes and the ability to solve life problems;
- all forms of institutional and non-institutional activities addressed to people diagnosed with the pre-suicidal syndrome;

[3] I offer a detailed analysis of the factors conditioning depressive disorders and suicidal behavior in Determinants of Suicidal Behavior in Adolescents. A Review of Selected Studies (2019), *Pedagogical Yearbooks KUL*, *11*(47), 357–371.

- organization of various specialist trainings addressed to different professional groups, including teachers, who will shape and raise public awareness of the phenomenon of suicidal behavior and its determining factors;
- interdisciplinary scientific research on suicides, their determinants and scale;
- shaping youth awareness of the occurrence of mental discomfort as an effect of the youth crisis;
- invalidating the stereotype indicating mental illness as a determinant of suicidal behavior (WHO, cited in Prusik, 2015, p. 104).

When analyzing the factors proposed by WHO, it should be remembered that the effectiveness of preventive measures depends on many factors, the participation of parents – and sometimes different institutions – in particular. This is confirmed by C. Hooven's research (2012) which stresses the need to strengthen family relationships, increase risk awareness and create educational, preventive and therapeutic programs for people involved in raising and educating children and youth. In turn, Joyce L. Epstein (2002) focuses on preventive measures based on the partnership and cooperation of the three main environments influencing children and young people: family, school and the local (social) environment. In her model, these spheres of influence often overlap, with the individual (child/student) remaining in the center of them. The overlapping of these environments, in turn, helps create a community based on common bonds. Epstein enumerates the following types of cooperation: communication, volunteering, home education, co-decision and collaboration with the local environment. Their goal should be to facilitate the participation of school graduates in creating preventive programs for students, to organize local initiatives aimed at minimizing depression, to inform students and parents about different forms of spending free time and local culture centers, to offer support for families and students who need it, as well as to stress the importance of school and family in municipal activities (Rogala, 1989).

The implementation of preventive measures regarding depression and suicidal behavior in Poland should be a continuous process that requires many treatments, observations and procedures in which the child is the most important subject. Prevention should involve all the environments (areas) in which the child lives and functions. It should, in fact, integrate them by means of taking into account both the problems and opportunities occurring in them. Importantly, preventive measures should be coherent and lead to the creation

of a "support network" in the local environment, which could then become involved in the creation of global prevention projects (Przybysz-Zaremba & Katkonienė, 2014, pp. 56–57). Meanwhile, various institutions, including primarily schools, carry out prevention only in their own, local environments, which does not always allow for integration with various types of institutions. Therefore, the effectiveness of these measures is relatively low.

Aside from family, school is, in fact, the child's most important educational environment. Consequently, focus should be on the implementation of three different levels of prevention: universal, selective and indicative. Each of them should include activities reflective of the degree of suicide risk. Universal prevention, therefore, along with health promotion, is addressed to all – students, teachers, parents and people working directly with children. Its main goal is to care for the proper development of the child, to meet their need for safety and to create a proper (friendly) educational environment for them. At this level of prevention, it is important to build good relationships between teachers and students, parents and students, as well as among the students themselves, and thus strengthen the students' resistance to emotionally difficult and stressful situations. It is equally significant to raise their self-esteem by giving them the opportunity to develop their own interests and experience success, as well as enable them to build their sense of connection with other students and to let them know what people and institutions they can turn to in case of problems (Szymańska, 2012, pp. 20–21).

Selective prevention, on the other hand, involves working directly with a person in crisis. It is addressed to high-risk groups (e.g., children and adolescents with various types of disorders, learning difficulties, and family and peer problems). The main emphasis at this level of prevention should be on diagnosing the needs and difficulties the individual is facing. Assistance, support, building the motivation to act and facilitating the student's inclusion in a peer group are other important factors to be implemented at this level. Specialists recommend including the individual in additional programs which help develop psychological and social skills, as well as intensifying cooperation with parents (Szymańska, 2012, pp. 20–21).

As for indicative prevention, this is addressed to individuals at high suicide risk (e.g., young people after a suicide attempt, with a history of suicide in the family, experimenting with psychoactive substances, diagnosed with depressive disorder or other mental illnesses). At this level of prevention, the focus is laid on continuous and discreet observation carried out by properly

trained professionals, the help and support of teachers in learning, constant cooperation with parents, specialist care (especially when the inability to solve problems and feelings of powerlessness occur) and the participation of parents in workshops and therapeutic classes aimed at acquiring appropriate skills useful in the care and education of children with a depressive disorder and suicidal behavior (Szymańska, 2012, p. 22).

The goals and tasks mentioned above should include cooperation with specialist institutions (especially in the case of selective and indicative prevention) and actively involve family members who, through everyday interaction with the child, can spot the first symptoms of depression and suicidal behavior.

Review of selected depression and suicidal behavior prevention programs addressed to children and adolescents

In Poland, various depression prevention programs are being carried out;[4] some are addressed to adults, some to minors, and their extent is either nationwide or local. Due to their variety and diversity, and in view of the limitations on the length of this paper, I will discuss only one of the programs – one aimed specifically at minimizing depression among children and adolescents. The "Program for the Prevention of Depressive Disorders in Children and Adolescents" was implemented in the years 2010–2013 in schools in the Lodz region. It was addressed to students aged 11–16. Its main goal was to reduce the incidence of full-blown depression in students by identifying risk factors and to reduce these factors through intervention in the form of workshops. The priority of the program, therefore, was to reduce the risk of depression, with suicide being its most dangerous outcome. The therapeutic workshops were conducted in the following modules: training of social skills (including conflict resolution skills), naming and expressing feelings, techniques of coping with

[4] See: "Program for the Prevention of Depression in Poland for 2016–2020" developed at the request of the Minister of Health (http://www.mz.gov.pl/zdrowie-i-profilaktyka/programy-zdrowotne/wykaz-programow/ depression-prevention-program in Poland-for-years-2016-2020 [accessed: 4.05.2017]); "Prevent Sadness" prevention program implemented by the Specialist Hospital dr. J. Babiński in Krakow in cooperation with the Poviat Hospital in Limanowa, with the financial support of the Lesser Poland Voivodeship (http://www.profilaktykaw-malopolsce.pl/depresja [accessed: 4.05.2017]); the government's program "Zero Tolerance for School Violence" which aims to prevent aggressive and violent behavior, closely related to self-destructive behavior, (Warchoł, https://ziladoc.com/download/problem-samobojstw-wrod-modziezy-propycje_pdf [accessed: 20.08.2019], p. 11).

stress and negative emotions and psychoeducation in the field of depression disorders for children and their parents (Felcenloben & Gmitrowicz, 2015, pp. 131–136).

Schools outside of Poland also implement various depression and suicide prevention programs. Below, I list some of the programs introduced in American schools that are addressed to children, adolescents, as well as the people working with them that were described by B. Hołyst (2007, pp. 31–39). These are:

- "General Suicide Education" which aims to spread and promote knowledge about this phenomenon, to shape social skills necessary to improve the quality of life in young people and to motivate them to seek help in difficult situations.
- "School Gatekeeper Training Programs" and "Community Gatekeeper Training Programs" that offer training and courses for educational staff to teach them to diagnose symptoms of suicidal behavior and intervene when necessary.
- "Peer Support Programs" offering various types of workshops to people at high risk of depression to assist them in problem solving and to have them benefit from peer assistance and offer it to others.
- "Screening Programs" that aim to detect people who are at high risk of committing suicide. To this end, specialized tests and interviews are carried out, taking into account the following predictors of suicide: the occurrence of suicide attempts (from 25 to 40% of suicide victims had made unsuccessful suicide attempts in the past), high levels of depression, feelings of hopelessness and powerlessness, manifestations of anti-social behavior, alcohol and drug abuse, inability to experience life satisfaction and low self-esteem.
- Crisis Centers and Hotlines, available 24 hours a day, which offer comprehensive specialist assistance (psychologists, educators and therapists) to help people in crisis.
- "Intervention After a Suicide Programs" which are mainly used in schools where a student has committed suicide. The main purpose of these programs is to prevent the phenomenon of suicide from escalating.

In their article "Prevention of Depression in Children and Adolescents: Review and Reflection," Óscar Sánchez-Hernández, F. Xavier Méndez and Judy Garber (2014) review a variety of studies (including their own), on the basis of which they discuss several prevention programs. Table 1 lists some of

them, noting their authors, the age groups to which they are addressed, their goals, forms and duration.

Table 1
Overview of selected depression and suicidal behavior prevention programs for children and adolescents

Program Name	Author (Authors)	Addressees	Goals	Form	Duration
Penn Resiliency Program (PRP)	Gillham, Jaycox, Reivich, Seligmany Silver (1990)	Children and adolescents up to the age of 15	– learning how to distinguish between pessimism and optimism; – improving strategic decision making; – developing social skills	– interpersonal skills and problem-solving training; – developing social skills	Twelve 90-minute sessions
Coping with Stress Course (CWSC)	Clarke, Hawkins, Murphy, Sheeber, Lewinsohny Seeley (1995)	Young people aged 13–17	– eliminating negative thoughts; – how to deal with recurring negative thoughts and moods; – work on reaching agreement with parents and/or legal guardians; – elimination of passivity; – developing social skills	– cognitive restructuring; – relaxation; – conflict solving; – undertaking all activities conducive to the above	Fifteen 45-minute sessions
Problem Solving for Life (PSFL)	Spence, Sheffieldy Donovan (2003)	Young people aged 13–15	– eliminating negative thoughts; – how to face Problems	– cognitive restructuring; – troubleshooting	Eight 45–50-minute sessions
Interpersonal Psychotherapy – Adolescent Skills Training (IPT-AST)	Youngy Mufson (2003)	Adolescents (11–16 years of age)	– coping with life difficulties; – resolving disputes and interpersonal conflicts; – overcoming interpersonal deficits	– developing communication skills; – developing social skills	Ten 90-minute sessions
Resourceful Adolescent Program – Adolescents (RAP-A)	Shochet, Dadds, Holland, Whitefield, Harnetty Osgarby (2001)	Youth aged 12–15	the "eradication" of suicidal thoughts; – how to face problems; – promoting harmony and peace in relationships with parents, guardians, and other people; – how to avoid conflicts with parents and guardians	– cognitive restructuring; – troubleshooting; – developing communication skills; – developing social skills	Eleven 40–50-minute sessions

Source: own study, based on: Sánchez-Hernández, Méndez & Garber, 2014, p. 65.

It is important to remember that the selected prevention programs for depression and suicidal behavior presented above require confirmation of their effectiveness. The researchers listing them, in fact, do not comment on their efficacy, rather, they treat the programs as suggestive of preventive measures that could contribute to minimizing depressive disorders and suicidal behavior in children and adolescents. It should be emphasized, therefore, that the success of these preventive programs depends on many factors which include, among others, the knowledge and competence of the people implementing them and their skills in making a correct diagnosis of the situation and disorders manifested by children and young people – a necessary basis for the proper selection of methods, techniques and tools used in a given program. The approach and flexibility of the people implementing the program, their willingness to modify or replace previously chosen methods at the right moment thanks to their relationship with the students included in it, is extremely important. It is equally important to create the right circumstances for discovering the students' hidden potential, which could then contribute to changes in their behavior (Przybysz-Zaremba, 2017, p. 326).

Summary and conclusions

The studies and statistics cited in this article indicate that depression and suicidal behavior among children and adolescents pose an important, complex problem that is growing in modern society. As such, this problem requires well-thought-out, integrated and diagnostic-based preventive measures involving both the individual affected by the problem and the environments in which they live, function and fulfil their needs. Diagnostics (of individuals and their environments) should be a fundamental element in constructing programs for the prevention of depression and suicidal behavior, as it creates the opportunity to minimize (and sometimes completely eliminate) the so-called risk factors (individual, family, school and environmental ones), as well as to modify and strengthen protective factors (see: Przybysz-Zaremba, 2017, pp. 55–71). A detailed analysis of the etiology and determinants of depression and suicidal behavior is also important in undertaking actions and designing preventive programs. According to Bruno Hołyst (2007, p. 31), the structure of preventive programs should likewise take into account the age of the people to whom a program is addressed, as well as touch on certain aspects directly related to the individual to whom the problems relate, namely: "a) seeking the

meaning of life, strengthening positive character traits and positive attitudes towards life; b) shaping attitudes of kind and active involvement in human affairs; c) following the principle of rational goodness, which means helping others without taking away their initiative and the ability to solve problems on their own; d) shaping mindfulness attitudes, thanks to which it is possible to recognize the symptoms of resignation behaviors; e) disseminating knowledge about depressive disorders and suicidal behavior (suicide); f) developing the ability to cope with difficult situations" (Hołyst, 2007, p. 31). Such preventive measures should be implemented in the family at an early stage of the child's life, as well as in childcare institutions, nurseries and kindergartens, and then fixed in educational institutions which, at least to some extent, have been established to perform this very role.

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